



FLEXIBLE BENEFITS PLAN

ELECTION FORM

Effective January 1, 2015 through December 31, 2015

PLAN INFORMATION

EMPLOYER NAME: Washington County

PLAN YEAR: 2015

PLEASE PRINT OR TYPE

EMPLOYEE INFORMATION

NAME			DATE OF HIRE	SOCIAL SECURITY NUMBER	
LAST	FIRST	MI			
HOME ADDRESS					
NUMBER AND STREET		CITY	STATE	ZIP CODE	
DATE OF BIRTH	E-MAIL ADDRESS		PHONE NUMBER	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	
PARTICIPANT'S EFFECTIVE PLAN DATE _____			DATE OF FIRST PAYROLL DEDUCTION _____		

ELECTION INFORMATION

I understand that the rules of the Internal Revenue Code allow me to use part of my salary on a pre-tax basis to purchase one or more of the following benefits. I hereby elect to participate in my employer's Flexible Benefits Plan as indicated below.

BENEFIT ELECTIONS OPTIONS	ELECTION	DEDUCTION		
HEALTH CARE FLEXIBLE SPENDING ACCOUNT (FSA) You can elect a maximum of \$ 2550.00 per plan year.	Yes No <input type="checkbox"/> <input type="checkbox"/>	\$ _____ PER PAY PERIOD	No. of Paychecks	\$ _____ ANNUAL
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (DCA) NOTE: DCA IS FOR CHILDCARE SERVICES ONLY Maximum of \$5,000 per Plan Year if single parent or is married and filing a joint return. Maximum of \$2,500 if married and filing separately.	Yes No <input type="checkbox"/> <input type="checkbox"/>	\$ _____ PER PAY PERIOD	No. of Paychecks	\$ _____ ANNUAL

I have reviewed and understand the terms and conditions of this plan. I understand that I can not change or revoke this election at any time during the Plan Year unless I have a Qualifying Life Event change (including marriage, divorce, death, birth or adoption of a child, change or termination of spouse's employment, change in dependent care provider or such other events as the Plan Sponsor determines will permit a change or revocation of an election). I further acknowledge that I am responsible for keeping all receipts verifying all eligible expenses and must submit such receipts to my plan administrator for claims substantiation.

☐ YES, the benefits of the Plan have been explained to me and I elect to participate as indicated above.

OPTIONAL:

☐ I would like to request an additional card for my spouse or tax dependent. Cards are issued to the name of the user therefore, we need the name and social security of who you authorize a card to be issued.

There is an additional \$5.00 fee per card.

Name _____

Social Security Number: _____

PARTICIPANT'S SIGNATURE X _____	DATE _____
HR'S SIGNATURE X _____	DATE _____

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